DURABLE MEDICAL EQUIPMENT PAYMENT SYSTEM

*payment***basics**

Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about $7 billion on DME in 2003, about 3 percent of fee-for-service program spending. Spending on some categories of DME have been growing rapidly over the past several years. For example, spending for wheelchairs and drugs administered through DME grew 84 percent and 54 percent, respectively, from 2001 to 2003.

Wheelchairs and respirators are typical of the equipment Medicare pays for under this benefit. To be covered, the equipment must:

- withstand repeated use,
- primarily serve a medical purpose, and
- generally not be useful to a person without an illness or injury.

Thus, expendable supplies, such as bandages or incontinence pads, or otherwise useful equipment such as a humidifier, would not be covered under this benefit.

Medicare also covers prosthetics, orthotics, and some medications under its DME benefit. Covered prosthetics generally are artificial limbs; orthotics include orthopedic braces and some supportive garments. Medication that is necessary to the function performed by durable equipment is also covered under this benefit—for example, heparin administered in a home dialysis system or albuterol in a nebulizer.

All program payments are reduced by the 20 percent coinsurance paid by beneficiaries.

The equipment Medicare buys

Medicare uses fee schedules to set prices for noncustomized equipment, prosthetics, and orthotics. These items are assigned to categories and to product groups within those categories. The categories are based on the nature of the item: whether or not it is inexpensive, needs frequent service, or is a rental item subject to an explicitly limited period of use. The categories are:

- inexpensive or routinely purchased equipment,
- items requiring frequent and substantial servicing,
- prosthetic and orthotic devices,
- capped rental items, and
- oxygen and oxygen equipment.

Within the categories, items are further categorized into about 2,000 product groups. Examples of product groups are high-strength lightweight wheelchairs and rental portable oxygen systems. All items within the same product group have the same payment rate.

Setting the payment rates

Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the consumer price index for all urban consumers to account for inflation. Several exceptions to this general rule are:

- Customized equipment and medications are paid at rates that are determined item by item, by the regional carrier.
- Prices for most medications used in conjunction with DME are set at 106 percent of the average sales price (ASP). Drugs used with infusion equipment are paid at 95 percent of average wholesale price (AWP).
- Prices for home oxygen are based on the median 2002 Federal Employee Health Benefit plan price.

To capture geographic differences in prices for equipment, Medicare uses a separate fee schedule for each state. The program pays the lesser of the provider's

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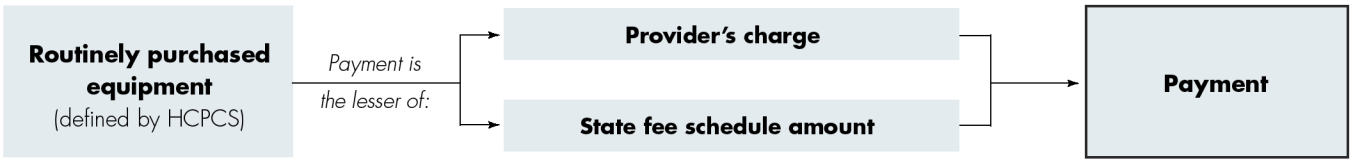
Figure 1 Durable medical equipment payment system



Note: HCPCS (Healthcare Common Procedure Coding System).

charge and the state fee schedule amount (Figure 1). State fee schedule rates are subject to a national floor and ceiling to limit the variability in prices across the country. The fees for prosthetics and orthotics are also determined state by state but are subject to regional limits. There are no state or regional variations in the price of drugs that Medicare purchases through this benefit. The applicable fee schedule is determined by the location of beneficiaries' residences rather than the location of the DME provider.

Competitive bidding

Qualified suppliers were allowed to bid against one another to test a new method of pricing and purchasing DME in two areas between 2000 and 2002. As an incentive to compete, suppliers whose bids were not among the lowest priced were excluded from the market or not allowed to serve new clients. In that demonstration, competitive bidding lowered prices for selected DME items between 17 and 22 percent. Analyses of the demonstration did not find serious quality or access issues.

Based on the results of the competitive bidding demonstration, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a competitive bidding process for DME that will be phased in nationwide, starting with 10 metropolitan statistical areas (MSAs) in 2007 and expanding to 80 MSAs by 2009. In areas without competitive acquisition after 2009, Medicare may either apply competitive bidding payment rates from other areas or survey markets outside of the Medicare program and apply those prices if they are substantially different from Medicare's prices (the "inherent reasonableness" authority). Class III devices—those the Food and Drug Administration has categorized as new, unique, or new uses of a product—are exempt from the competitive bidding process. Also, the Secretary is required to establish quality standards for DME and implement them through independent accreditation organizations. ■